Definition of 'Meaningful Use' Poses Challenges for Hospitals

Meeting Criteria for Pharmacy Software And Electronic Medical Records Will Be Difficult

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Hospitals are increasingly worried that they will not be able to tap into the first-year flood of stimulus dollars committed to health information technology (HIT). These funds are scheduled to begin flowing next fall. The American Recovery and Reinvestment Act (ARRA) set aside about $17 billion for hospitals and physicians who can demonstrate "meaningful use" of HIT starting in fiscal year 2011, which begins on October 1, 2010. Hospitals that qualify in fiscal year 2011 would receive payments that could amount to $8 million or more over a period of four years. Hospitals that qualify in subsequent years would get less money, although the minimum would be $2 million. Those funds are meant to compensate hospitals for HIT software that they had *previously* purchased. If a hospital has not demonstrated meaningful use by 2015, its Medicare reimbursement rate might be decreased by 1% per year up to a potential maximum penalty of 5%.

Hospital leaders have criticized the definition of meaningful use, as developed by the Centers for Medicare and Medicaid Services (CMS), in the proposed rule it issued on January 13, 2010. The rule contains 23 objectives that hospitals would have to meet through their HIT systems in order to claim meaningful use. The rule also proposes that hospitals must report 35 clinical quality measures through an electronic health record (EHR). Those are just the stage 1 requirements. Additional stage 2 and 3 requirements must be met in 2013 and 2015 to keep incentive payments flowing—and to avoid payment cuts in 2015.

Reflecting the general unease of hospitals with the interim final rule on meaningful use, the College of Healthcare Information Management Executives (CHIME) sent comments to the Department of Health and Human Services (DHHS) on February 26. One of its critical concerns is that the regulations outline an "all-or-nothing" approach to defining and achieving meaningful use that is too ambitious, does not take into account the need for flexibility by providers, and does not reward incremental progress. In its recommendations, CHIME wants CMS to give health care providers until 2017 to accomplish the following:

- achieve all components for implementing an EHR
- develop an expanded suite of 34 core objectives, with some of these requirements expanding over time
- use an incremental approach that would consider a provider a "meaningful user" if it achieves 25% of objectives by 2011, 50% by 2013, 75% by 2015, and substantially all of them by 2017

Chuck Christian, Director of Information Systems and Chief Information Officer for the Good Samaritan Hospital in Vincennes, Indiana, says:

"I'm not sure anyone will be able to make that October 1 deadline for proving meaningful use. If we got very aggressive, we would still be two years out, and we have spent 10 years building our clinical electronic system."

Karl F. Gumpper, RPh, BCNSP, BCPS, Director of the Section of Pharmacy Informatics & Technology at the American Society of Health-System Pharmacists (ASHP), notes that hospitals will need 90 days of data to show that they meet the definition. This means that hospitals could begin complying as late as July 2010 and still receive fiscal year 2010 payments.

One of the 23 objectives cited by the CMS is that physicians in hospitals use computerized prescriber order entry (CPOE) for a minimum of 10% of the orders that they write. That CPOE must cover medications. Mr. Christian argues that this requirement, like some of the others, is misdirected because hospitals can do a lot better in preventing medication errors and adverse drug reactions—an important rationale for CPOE—via bar codes on drug packages, nurses' wrists, patients' wrists and charts, and so forth. (Bar coding is also discussed this month on page 212.)

A significant objective for pharmacies would be to perform medication reconciliation at each transition of care, from the point at which patients are admitted, to the point where they are assigned a hospital bed, to when they actually receive medication from a nurse, and to when the patient is discharged. At each of those steps, the hospital must ensure that the drugs taken by the patient are not contraindicated. The criteria for meaningful use are that reconciliation must be done electronically; however, many patients are admitted to the hospital and have been taking previously prescribed drugs, paying for them out of pocket. Because there is no electronic version of those purchases, this requirement poses challenges for electronic reconciliation. Mr. Christian points out, too, that the CMS has not adequately defined two terms relevant to the reconciliation requirement—"relevant encounter" and "transition of care."

Another objective is medication administration for alerts at the point of care to accomplish real-time drug–drug, drug–allergy, and drug–formulary checks and to maintain an active medication list.

Not only would hospitals have to meet the meaningful use definition; they would have to do so with software that is properly certified. The problem is that DHHS

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has not stated how the software will be certified. It is presumed that the industry-controlled Certification Commission for Health Information Technology (CCHIT) would be involved and that perhaps software it has previously certified will be "grandfathered" into whatever certification system DHHS finally decides on. No final rule on this subject has appeared. About two dozen software vendors have achieved the CCHIT's latest certification, which aligns fairly closely with the certification standards published by DHHS on January 13, 2010, in the interim final rule it issued, which came out the same day as the meaningful use proposed rule from the CMS.

Hospitals face substantial challenges in meeting the stage 1 definition of meaningful use and in obtaining the first share of federal grants. Yet consumers will likely see facilities that do grab the brass ring as not just technologically edgy but also as providers of quality health care. ■